# Domestic Violence—A Medical Perspective

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One of the patients awaiting treatment is a well-dressed middle-aged woman with back injuries from a fall down the stairs. Another is a university student waiting for x-rays of a spiral wrist fracture she suffered while playing volleyball. Many others, of all ages and ethnic backgrounds, are seeking treatment for problems as varied as acute anxiety, depression, attempted suicide, severe headaches, eating and sleeping disorders, pregnancy complications, chronic pain, or substance abuse. What do all of these women have in common? They are all victims of battering who are seeking medical treatment for abuse-related problems.

In a society that is still waking up to the reality that domestic violence is a serious crime, and not a private, family matter, another important facet of this age-old problem has recently begun to surface. New research is making it increasingly evident that we must acknowledge and address domestic violence in America as a major health care concern.

According to the U.S. Surgeon General, battering is the single most common cause of injury to women, resulting in more injuries than all auto accidents, rapes, and muggings combined. Domestic violence is such a common health problem that it is responsible for annual medical expenses totaling $3 to $5 billion, and businesses forfeit at least another $100 billion each year in sick leave, lost wages, absenteeism, and nonproductivity. Despite the huge number of victims, however, the U.S. Surgeon General estimates that only 5% of all battered women who seek medical care are identified as domestic violence victims.

An astonishing study recently released by the American Medical Association Council on Scientific Affairs reveals that approximately 22% to 35% of all women patients in emergency rooms are there for treatment of on-going abuse—either injuries or related symptoms. For the many women who require emergency surgical services each day, a full 50% have injuries caused by battering.

These new figures have prompted many concerned health care professionals to begin carefully reexamining the charts of all female patients with histories of repeated injuries and to also start routinely questioning every female patient about possible abuse.

Perhaps an even more shocking finding in the same report is the astounding conclusion that 37% of all obstetric patients—across class, racial, and educational lines—are physically battered while pregnant. Pregnancy has been identified as a particularly high risk time for abused women who often suffer attacks purposely directed at the abdomen, and who suffer miscarriages at 3 to 5 times the rate of non-battered women. Assaults during pregnancy can cause severe trauma to the fetus as well as to the mother, and frequently result in low birth weight, pre-term labor, or birth defects. According to the March of Dimes, more birth defects are caused by battering during pregnancy than by the combination of all diseases and illnesses for which pregnant women are immunized.

In addition to causing serious physical trauma, domestic violence has proven to be one of the most significant contributors to a wide variety of other physical and mental problems for women. Despite the fact that it is often the hidden root cause of a woman's deteriorating health, it is rarely identified and treated as a source of illness.

Abuse typically follows a pattern and becomes more frequent and more severe as time passes; therefore, a battered woman's health may reflect corresponding stages of increasing medical complexity. This progressive nature of violence commonly leads to a victim's utilization of various medical and social services. If a health care provider is trained to recognize this continuum of symptoms, an opportunity to give support and appropriate referrals is provided.

Medical problems resulting from abuse usually begin subtly as a victim is subjected to escalating emotional, psychological, or physical abuse. Routinely harassed, humiliated, and forced to walk on eggshells, a victim may become overwhelmed by extreme tension. The constant stress she experiences can lead to any number of illnesses.

Research has revealed many of the physical symptoms that can evolve for women who live with abuse. Among those that occur commonly are chronic headaches, fatigue, insomnia, gastrointestinal disorders, depression, anxiety, chronic pain, eating disorders, muscle aches, pregnancy problems, hypertension, vague complaints, and even arthritis and heart disease.

When symptoms such as these begin to affect a woman's health significantly, she is likely to seek medical treatment. Making a concrete diagnosis often is a difficult task for practitioners, since abuse and fear of reprisal may prevent a patient from openly revealing the abuse. Studies indicate, however, that when questioned with empathy and in private, most battered women are actually relieved and will respond honestly to questions.

Unfortunately, research has revealed that the most common medical response to abused women is to prescribe either tranquilizers, hypnotics, or pain medications. Because of the medical community's lack of information about domestic violence, an estimated 1 in 4 battered women leaves the health care setting with the diagnosis "hysterical," "neurotic," "hypochondriac," or "a well-known patient with multiple vague complaints." Patients labeled in this manner are typically referred to mental health professionals and not to the much-needed domestic violence services. As a result, victims may believe they are *sick* or *crazy*, something they have probably heard often from their abusive partner. More frustrated and confused than ever, the majority of these victims return home where the danger to them continues to escalate.

For many battered women, a stress-induced physical illness will lead to increased social isolation. As their health suffers from the negative effects of abuse, they may be less able to fulfill outside obligations or commitments. They may be forced to stop going to work, school, or church, and may have to reduce the time spent with supportive family or friends. While confined to home with health problems, they are more accessible to their partner's violence, and therefore are likely to become even more severely abused. In many cases, as a victim's confusion and frustration increases, her health continues in a downward spiral into substantial psychosocial problems.

Drug or alcohol abuse, severe depression, and suicide attempts are among the very serious conditions for which a battered woman may ultimately find herself being treated These common responses to ongoing abuse are unfortunately often misinterpreted as the cause of the abuse. To the contrary, such outward manifestations often indicate a victim's desperate desire to escape the hostage-like situation established by her partner's power and control tactics. Other emotional symptoms that may follow constant abuse include emotional shock, denial, withdrawal, confusion, psychological numbing, or PTSD (Post Traumatic Stress disorder, the psychological phenomenon experienced by many Vietnam veterans).

According to the AMA study, psychosocial symptoms related to battering are so common that they account for 64% of all females hospitalized with psychiatric problems. Another new report reveals that domestic violence victims make up at least 25% of all women receiving outpatient mental health services.

Research on women who attempt suicide has resulted in estimates that as many as 25% to 50% do so in response to domestic violence situations. Thankfully, an increasing number of these cases are being identified by alert medical providers who are referring victims appropriately to shelters and domestic violence counseling. One young woman, who nearly succeeded in taking her life recently, told a HOPE For Battered Women counselor, "I'm so tired. I just wanted peace. I wanted to die so he would leave me alone." Her attitude is not unusual. Many battered women are convinced there is no other way to escape their abuser.

For the battered woman, there does remain at the far end of the medical continuum the tragic possibility of death by either suicide or by murder at the hands of her partner. Approximately

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menopausal women with hypertension, and if blood pressure increases while they are receiving this treatment, it is unlikely that the estrogen is the cause of the blood pressure elevation. There is no epidemiologic evidence of an increased incidence of thrombophlebitis or thromboembolism in postmenopausal estrogen users as compared with control subjects.

An abundance of epidemiologic data indicates that estrogen replacement therapy retards the development of atherosclerosis in postmenopausal women and reduces their risks of developing myocardial infarctions and cerebrovascular accident (CVA, stroke) by about 50%. The main mechanism whereby oral estrogen replacement retards atherosclerosis postmenopausally is prevention of the adverse alterations in endogenous circulating lipid levels that normally occur after the menopause, but estrogen also acts directly on the arterial system to improve blood flow.

Much concern has been raised about the neoplastic risks of postmenopausal estrogen replacement therapy, particularly breast and endometrial cancer, since these areas are estrogen target tissues.

The possibility exists that estrogen can stimulate a nonpalpable breast cancer, and carcinoma of the breast can exist in the preclinical state for as long as 8 years before it is palpable. Therefore it is advisable to obtain a mammogram to rule out subclinical breast cancer on all patients before initiating estrogen therapy and annually thereafter.

Many epidemiologic studies have investigated the relation of exogenous estrogen and the incidence of breast cancer. The epidemiologic data generally are reassuring as most studies show no increased risk of development of breast cancer among postmenopausal estrogen users, with the possibility of a slightly increased risk with long-term use. At present, it is not clear what effect if any the addition of a progestin to estrogen replacement therapy has on the risk of breast cancer.

Many epidemiologic studies have reported there is significantly increased risk of endometrial cancer developing in postmenopausal women who are ingesting estrogen without progestins as compared with non-estrogen users. The risk increases with increasing duration of use of estrogen and with increasing dosage. The endometrial cancer that develops in estrogen users is nearly always well differentiated and is usually cured by performing a simple hysterectomy. The risk of developing endometrial carcinoma for women receiving estrogen replacement can be markedly reduced by giving progestogens. The use of progestins lowers the chances of postmenopausal estrogen users' developing cancer of the endometrium, and therefore progestins should usually be given to postmenopausal women receiving estrogen if they have a uterus. The addition of a progestin to estrogen therapy does not appear to cause an increase of any other systemic disease and acts synergistically with estrogen to cause a slight increase in bone density. The use of synthetic progestins, however, may reverse the beneficial effect of estrogen upon serum lipids.

One of the primary reasons that postmenopausal women decide not to use estrogen, or discontinue its use, is the occurrence of uterine bleeding. For this reason, combination instead of sequential estrogen-progestin regimens are being increasingly prescribed as the former regime is usually associated with no bleeding after the first few months. For women without a uterus it is unnecessary to add a progestin.

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4,000 women are killed in the U.S. each year by their current or former partners, with the great majority of these murders occurring after the woman has ended the relationship. During the 1980s alone, an estimated 50,000 American women died as a result of domestic violence. Incredibly, this figure nearly matches the number of U.S. fatalities for the Vietnam war.

How are we as a society to respond to this new understanding of domestic violence as a medical crisis? One way to begin is by providing training for health care providers and insisting that medical schools include domestic violence education in their curriculums—medical providers have the potential to reach countless victims. Since almost all battered women must occasionally see family doctors, pediatricians, dentists, counselors, or others in the health care field, opportunities abound to recognize the indicators of abuse and to make referrals to life-saving resources.

In order to heighten the awareness of the medical community, and society at large, however, we must begin as individuals to shed our own heavy denial, which protects us from facing the true enormity, severity, and randomness of domestic violence. We must shatter our outdated stereotypes about why abuse occurs once and for all, and exactly who "those people"—victims and batterers—really are. In addition, we must stop blaming the victim by constantly asking, "Why does she stay?" and instead refocus our attention and indignation on the person using the violence by asking, "Why does he hit?"

Coming to terms with any unpleasant social truth is an uncomfortable experience. To let go of denial and grasp, for perhaps the first time, the truly devastating ramifications of domestic violence is especially disturbing. There is no going back. But until we as individuals are willing to risk some degree of personal discomfort in exchange for the truth, we will be robbing ourselves of golden opportunities to help many victims—perhaps even our own co-workers, neighbors, friends, sisters, daughters, or mothers—who may someday tell us that their injuries are from a "fall down the stairs" or from "playing volleyball."

*Editor's Note*
***In 1989, after surviving a brutal attack in which she was beaten and stabbed by her estranged husband, Julie Owens left her career in special education and devotes her full-time efforts to the field of family violence. She gives domestic violence training seminars to professionals and trains officers and counselors in the Honolulu Police Department's DART program (Domestic Abuse Response Team).***